

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01716

CERTIFICATE OF DEATH

01699

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Maryland</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ralph Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>Ralph AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Cleveland</u> Last <u>ARNOLD</u>		4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 4. 1891</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance MAN Railroad</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edgar ARNOLD</u>		14. MOTHER'S MARDEN NAME <u>Florence Burke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-02-6251</u>	
17. INFORMANT <u>Mrs Beatha Mae Arnold, Hampstead Md</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> (c) <u>Cerebral Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1960</u> to <u>February 9, 1962</u> that (I) (we) last saw the deceased alive on <u>Dec 12, 1962</u> and that death occurred at <u>9:30 P.M.</u> from the cause <u> </u> and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u>		22b. DATE SIGNED <u>Feb 12 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>HAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westminster, Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lipton-Gline Hampstead Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Quinn L. Kline</u>		25c. REGISTRAR'S SIGNATURE	

24520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G307 2/27/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

01700

01717

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Subsistence RD. Dist 17m.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>R.F.D. #6</u>	
3. NAME OF DECEASED (Type or print) <u>MARTHA</u> First <u>BAKER</u> Middle Last		4. DATE OF DEATH <u>FEB. 19</u> 19 <u>62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 1877</u> yrs.
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
12. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Addie Bollinger</u>		15. MOTHER'S MAIDEN NAME <u>Margaret Unverzagt</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Carcinoma of right Breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>3 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 19</u> , 19 <u>34</u> , to <u>Feb. 19</u> , 19 <u>62</u> that I last saw the deceased alive on <u>Feb. 14</u> , 19 <u>62</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D.		DATE SIGNED <u>Westminster, Md. 2-19-62</u>	
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>2/22/62</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Deer Park Cemetery</u>		<u>Amelwood Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>FEB 23 '62</u>		<u>Arthur S. Hines</u>	

01710

CHITRAKAL

1971

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Dr. B. S. Chitral

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01718
CERTIFICATE OF DEATH
01701

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Union Bridge		c. LENGTH OF STAY IN 1b Three Wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Westminster	
3. NAME OF DECEASED (Type or print) CHARLES C. BARNES		4. DATE OF DEATH Month Feb. Day 8 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1875
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body & Fender Mechanic (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S. A.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME James Barnes		14. MOTHER'S MAIDEN NAME Kitty Shipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-05-6530	
17. INFORMANT Address Mrs. Leighton Haifley, Same as # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Prostate		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/19/62 to 2/8/62 , 19 62 , that (I) we last saw the deceased alive on 2/5/62 , 19 62 , and that death occurred on 2/8/62 PM, from the causes and on the date stated above.			
22a. SIGNATURE J. H. Caricofe		22b. DATE SIGNED 2/8/62	
22c. PHYSICIAN'S NAME (Type) J. H. CARICOFE		22d. ADDRESS 118 S. MAIN ST. Union Bridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10, 1962	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Winfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Box 241, Sykesville, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01719 CERTIFICATE OF DEATH 01702									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 12yrs.3mos.26days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Formerly 3725 Ferndale Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ethel Middle Amelia Last Barnes					4. DATE OF DEATH Month February Day 11 Year 19 62				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 30, 1888		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis M. Barnes					14. MOTHER'S MAIDEN NAME Annie Rebecca Hardy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO S 21X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary abscess DUE TO (c) Psychosis with cerebral arteriosclerosis.								INTERVAL BETWEEN ONSET AND DEATH Days Weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 15, 1949 to February 11, 1962 that (I) (we) last saw the deceased alive on February 11, 1962 and that death occurred at 2:28 PM from the causes and on the date stated above.									
22a. SIGNATURE Agustin del Campo M.D.					22b. DATE SIGNED 2/11/62			22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield Hospital, Sykesville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-62		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons North & Pennsylvania Ave - Balt. Md.					25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

01505

01519



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg d. STREET ADDRESS 1 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sally (Sarah) Ann Knouse BARNES		4. DATE OF DEATH Month Day Year February 4, 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-86
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Knouse, dec.		14. MOTHER'S MAIDEN NAME Jane Mann, dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis, generalized. (c) Pulmonary tuberculosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis, minimal: active. CBS with cerebral arteriosclerosis, without qualifying phrase. 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State) 20i. (City or town) (County) (State) 20j. (City or town) (County) (State) 20k. (City or town) (County) (State) 20l. (City or town) (County) (State) 20m. (City or town) (County) (State) 20n. (City or town) (County) (State) 20o. (City or town) (County) (State) 20p. (City or town) (County) (State) 20q. (City or town) (County) (State) 20r. (City or town) (County) (State) 20s. (City or town) (County) (State) 20t. (City or town) (County) (State) 20u. (City or town) (County) (State) 20v. (City or town) (County) (State) 20w. (City or town) (County) (State) 20x. (City or town) (County) (State) 20y. (City or town) (County) (State) 20z. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1-27-61 to 2-4-62 , 19....., that (I) (we) last saw the deceased alive on 2-4-62 , 19....., and that death occurred at 4:45 a.m. from the causes and on the date stated above. 22a. SIGNATURE Agustin del Campo M.D. 22b. DATE SIGNED 2-4-62 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. 22d. ADDRESS Sykesville, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/7/62 23c. NAME OF CEMETERY OR CREMATORY Finksburg Mth. Cemetery 23d. LOCATION (City, town or county) (State) Finksburg, Md. 24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster, Md. 25a. REC'D BY REGISTRAR FEB 6 '62 25b. REGISTRAR'S SIGNATURE Clifford L. Hanes			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 12, MARYLAND
CERTIFICATE OF DEATH

01721

01704

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN TB 36 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY City Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 d. STREET ADDRESS 2823 Linwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stella First Middle Last Bartnik		4. DATE OF DEATH Month Day Year 2 11 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME -	
14. MOTHER'S MAIDEN NAME -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 715 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Large infected pressure sores DUE TO (c) Parkinsonism. C.B.S. with cerebral arteriosclerosis with psychotic reaction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Parkinsonism. C.B.S. with cerebral arteriosclerosis with psychotic reaction			INTERVAL BETWEEN ONSET AND DEATH days weeks
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1-6-1962 to 2-11-1962		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-6-1962 to 2-11-1962 , that (I) (we) last saw the deceased alive on 2-11-1962 , and that death occurred at 11:28 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 2-11-1962	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-15-62	
23c. NAME OF CEMETERY OR CREMATORY Bean Cemetery		23d. LOCATION (City, town or county) (State) SOMERSET, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14, Md.		25a. REC'D BY REGISTRAR FEB 16 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Kinner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Mr. Cook, 1000 East 1st St., Detroit, Mich.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, c. LENGTH OF STAY IN 1b 4ly 10m 9da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - Md. 3401.4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS Brought to this hospital from Bay View Hosp. no address given for pt. at time of admission, 1927 W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Karl ----- Beaumont		4. DATE OF DEATH Month Day Year 2 8 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 60-?		10. IF UNDER 1 YEAR Months Days 60-?	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Geseck		14. MOTHER'S MAIDEN NAME Maud Sheppard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial Failure DUE TO (c) Myocardial Fibrosis		INTERVAL BETWEEN ONSET AND DEATH Minutes Hours Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year How - a.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
20f. (City or town) -----		20g. (County) -----	
20h. (State) -----		21. I certify that (I) (this hospital) attended the deceased from....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.	
22a. SIGNATURE Naci N. Buyukunsal, M.D.		22b. DATE SIGNED 2/8/62.	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City, town or county) (State) Frederick Rd. Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George L. Schuch, 2101 Fredk. Ave., Balto - 7		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Travis			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01723 CERTIFICATE OF DEATH 01706									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b 4 mos. 28 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11 d. STREET ADDRESS 3350 Chestnut Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Leo Belchner					4. DATE OF DEATH February 6 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 18, 1894		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spray Painter			10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Andrew Belchner					14. MOTHER'S MAIDEN NAME Rosa McCarthy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-10-3844		17. INFORMANT Springfield Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Generalized arteriosclerosis DUE TO (c) Far advanced bilateral pulmonary T.B., Active PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Deferred. 002.1								INTERVAL BETWEEN ONSET AND DEATH Years Years Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-8-1961 to 2-6-1962 , that (I) (we) last saw the deceased alive on 2-6-1962 , and that death occurred at 4:15 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Agustin del Campo M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 2-6-62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					22d. ADDRESS Springfield State Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-9-62		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City/town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Wright ADDRESS Sykesville, Md.					25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur A. Wright		

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CENTRAL BANK OF INDIA

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01707

01724

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN b. <u>91 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Co. General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>25 Westmoreland St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BARBARA E. BELL</u>		4. DATE OF DEATH <u>Feb. 5 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1970</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9b. AGE (In years last birthday) <u>91</u> yrs.	9c. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Richom</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth BISTOL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Clarence R. Bell, Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V. disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall in bathroom</u>	
20c. TIME OF INJURY Hour <u>7</u> p.m. Month, Day, Year <u>1-20 1950</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>	20f. (City or town) <u>Westminster</u> (County) <u>Carroll</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Moore</u> EXAMINER'S NAME (Type) <u>JAMES J. MOORE</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>25 Westmoreland St, Westminster, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or country) <u>Westminster, Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR <u>J.E. Meyers, Jr., Westminster, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 8 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MEDICAL CERTIFICATION

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01708

1. PLACE OF DEATH e. COUNTY CARROLL COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD.		c. LENGTH OF STAY IN b. 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 WESTMINSTER, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HONE- 505 E. MAIN STREET				d. STREET ADDRESS 505 E. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PATRICIA ANN BOONE				4. DATE OF DEATH FEB 8 1962			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 23, 1962	
9. AGE (In years last birthday) 18		10. IF UNDER 1 YEAR Months 18 Days 18		11. IF UNDER 24 HRS. Hours 18 Min. 18			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) HANOVER, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PAUL C. BOONE				14. MOTHER'S MAIDEN NAME NETTIE R. STONESIFER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. —			
17. INFORMANT FATHER PAUL C. BOONE				Address 505 E. MAIN ST. WESTMINSTER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Congenital Abnormality Conditions, if any, which gave rise to immediate cause (b) 759.3 (a), stating the underlying cause last. (c) DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH - 16 days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Carroll							
ACTUAL SIGNATURE James T. Marsh		EXAMINER'S NAME (Type) JAMES T. MARSH		DATE SIGNED 2/8/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/62		22c. NAME OF CEMETERY OR CREMATORY KRIDER'S CEMETERY		22d. LOCATION (City, town, or country) (State) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR James B. Saffell				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01726 Items 23c & d, Film G307 2/20/62 iwk
01709

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 9days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS R#4, Box 173			
3. NAME OF DECEASED (Type or print) First Howard Middle Tracey Last Boyer				4. DATE OF DEATH Month February Day 14 , Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 10 Days X		IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. Boyer				14. MOTHER'S MAIDEN NAME Amanda Tracey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) Arteriosclerotic cardiovascular disease 422.1 } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Prostatic hypertrophy with urinary retention (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Possible malignancy.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/5/61 , 19 61 , to February 14, 1962 , that (I) (we) last saw the deceased alive on February 13, 1962 , and that death occurred at 6:20AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 2/14/62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-62		23c. NAME OF CEMETERY, OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.				25a. REC'D BY REGISTRAR FEB 15 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01727

01710

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY in 1b 6 mo. 15 dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34, Maryland d. STREET ADDRESS 9039 Simms Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Elizabeth Last Burgan		4. DATE OF DEATH Month 2 Day 27 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 82 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Grover		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield Hospital records - Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac insufficiency 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic brain syndrome with senile brain disease without qualifying phrase.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/12/1961 to 2/27/1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/27/1962 , and that death occurred at 11:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal M.D.		22b. DATE SIGNED 2/28/62	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-3-1962	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	23d. LOCATION (City, town or county) (State) Baltimore Md.
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR DATE MAR 5 '62	
25b. REGISTRAR'S SIGNATURE C. C. H. H.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01728
01711
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 26y. 1m. 26d. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 731 Reservoir Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Richardson Last Byrn		4. DATE OF DEATH Month 2 Day 7 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/74
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 2 Days 7	IF UNDER 24 HRS. Hours 19 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Richardson		14. MOTHER'S MAIDEN NAME Duhamel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Springfield Hospital records - Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid reaction, paranoid state.		INTERVAL BETWEEN ONSET AND DEATH ten days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/11 , 19 35 to 2/7 , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/7 , 19 62 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-10-62	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		25a. REC'D BY REGISTRAR FEB 13 '62	
ADDRESS 1900 Eutaw Place		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G307 2/26/62 iwk

01712

01729

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY in 1b <u>8mos. 29dys.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 31</u> <u>3101-4</u> d. STREET ADDRESS <u>1921 E. Fayette St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Clark</u>			4. DATE OF DEATH Month Day Year <u>February 9 1962</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1891</u>		9. AGE (In years last birthday) <u>71 70</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>-</u>			14. MOTHER'S MAIDEN NAME <u>-</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (b) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Moderately advanced - Pulmonary tuberculosis with circulatory disturbance with psychotic reaction.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>C.B.S. assoc.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Years.</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					<u>002.1</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Baltimore, Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>5-10-1961</u> to <u>2-9-1962</u> , that (I) (we) last saw the deceased alive on <u>2-9-1962</u> , and that death occurred at <u>7:15 a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin del Campo</u> M.D.				22b. DATE SIGNED <u>2-9-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>2/12/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maternity Bldg</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. H. H. H.</u>		24b. ADDRESS <u>Rivers & md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 1962</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01730					01713									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
a. COUNTY Carroll					a. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville					b. COUNTY City									
c. LENGTH OF STAY IN 1b 1yr. 5moths 16dys.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 31									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 311 Ballou Court West									
3. NAME OF DECEASED (Type or print)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
First Middle Last Marie Connie Cullum					4. DATE OF DEATH Month Day Year 2 11 62									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1889		9. AGE (In years last birthday) 72						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days 11 19						
13. FATHER'S NAME Frank. Deitz					14. MOTHER'S MAIDEN NAME Mollie Elizabeth Vogel									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. -					17. INFORMANT Springfield Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary abscess DUE TO (c) Bed sores										INTERVAL BETWEEN ONSET AND DEATH Days Weeks				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Late latent syphilis. Old myocardial infarction, years. C.B.S. assoc. with cerebral arterio. with psychotic reaction.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 026X									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) City						
21. I certify that (I) (this hospital) attended the deceased from 9-26-1960 to 2-11-1962 , that (I) (we) last saw the deceased alive on 2-11-1962 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.														
22a. SIGNATURE Agustin del Campo					22b. DATE SIGNED 2-11-1962									
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					22d. ADDRESS Springfield State Hospital, Sykesville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-15-62		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland								
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker					25a. REC'D BY REGISTRAR FEB 13 '62									
25b. REGISTRAR'S SIGNATURE Arthur S. Huns														

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CERTIFICATE OF DEATH

Reg. Dist. **Q1714**

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-New Windsor				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural New Windsor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETTY Middle DAVIS Last				4. DATE OF DEATH Month February Day 3 Year 19 62			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1877	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Blackstone, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Kelley				14. MOTHER'S MAIDEN NAME Indianna Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT 2541 Madison Ave. R. W. Young, Baltimore 17, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) General Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 11/4/62 , 19___, to 2/3/62 , 19___, that I last saw the deceased alive on 1/4/62 , 19___, and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. E. Robertson M.D.				ADDRESS (Street, city or town, state) New Windsor, Md DATE SIGNED 2/3/62			
PHYSICIAN'S NAME (Type) M. E. Robertson, M. D.				New Windsor, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1962		22c. NAME OF CEMETERY OR CREMATORY Mt. Garazene Cemetery		22d. LOCATION (City, town, or county) (State) Blackstone, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz ADDRESS Winfield-Md.				24a. REC'D BY REGISTRAR DATE FEB 7 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01711

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01732

01715

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, c. LENGTH OF STAY IN 1b 2yrs9mos10dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 d. STREET ADDRESS 612 S. Macon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Greason Eiler		4. DATE OF DEATH Month Day Year February 16 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1878 9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Joseph Greason		14. MOTHER'S MAIDEN NAME Elizabeth Ziegler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 4 20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized arteriosclerosis. (c) Diabetes Mellitus.		INTERVAL BETWEEN ONSET AND DEATH Years Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-6-1959 , to 2-16-1962 , that (I) (we) last saw the deceased alive on 2-16-1962 , and that death occurred at 8:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo. 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 2-16-62 22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-19-62	23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	23d. LOCATION (City, town or county) (State) 7225 Eastern Blvd., Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zailer ADDRESS 6224 Eastern Ave. Baltimore, Md.		25a. REC'D BY REGISTRAR FEB 20 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Pinner	

01312

01332

M

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01716**

01733

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Innsburg RD</u>		c. LENGTH OF STAY IN 1b <u>5 4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Innsburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cedarhurst Road</u>				d. STREET ADDRESS <u>Cedarhurst Road</u>			
3. NAME OF DECEASED (Type or print) First <u>MARSHALL</u> Middle <u>GUY</u> Last <u>FLATER</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1907</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Martin-Mannett Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Marshall Phillip Flater</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Ann Blizzard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>217-14-3686</u>		17. INFORMANT <u>Mrs Guy Flater, Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation - by hanging</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				DATE SIGNED <u>2-12-62</u>			
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>CARROLL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Innsburg RD. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr., Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 15 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01717

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr.6mos.2days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		10X-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Freed				4. DATE OF DEATH Month February Day 18 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1883		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Various		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Freed				14. MOTHER'S MAIDEN NAME Thannie Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-6286		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Severe arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Fracture, head of humerus.						INTERVAL BETWEEN ONSET AND DEATH years years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) Unknown.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. Feb. 7, 1962 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) James T. Marsh, M.D. 2/19/62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-62		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR FEB 21 '62		24b. REGISTRAR'S SIGNATURE Charles E. Hanna	

VS. A15ME
5M 7/59

01111

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

(M)

(1)

IN SENATE
JANUARY 10, 1911
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
ON THE
LANDS BELONGING TO THE STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01735

01718

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville - Rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bartholow Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville - Rural</u> d. STREET ADDRESS <u>Bartholow Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Lee Hutter</u> First Middle Last 4. DATE OF DEATH <u>Feb. 10 1962</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 29, 1961</u> 9. AGE (In years last birthday) <u>0</u> yrs. <u>4</u> mos. <u>12</u> days IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Oliver D. Hutter</u> 14. MOTHER'S MAIDEN NAME <u>Erma Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Mr. Oliver Hutter - Sykesville, Md.</u> Address <u>-</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Acute fulminating Bronchopneumonia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>-</u> DUE TO (c) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Sept 29</u> , 1961, to <u>Feb 10</u> , 1962, that (I) <u>was</u> last saw the deceased alive on <u>Feb. 6</u> , 1962, and that death occurred at <u>11:25</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sani Okutman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2.10.62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>		22d. ADDRESS <u>Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-12-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Pinner</u> ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Pinner</u>	

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281

CERTIFICATE OF DEATH

Reg. Dist. No. **01719****01736**

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 Winchester Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWARD FROCK</u>				4. DATE OF DEATH Month Day Year <u>Feb 18 1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1877</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Union Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel P. Frock</u>				14. MOTHER'S MAIDEN NAME <u>Alice Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Mrs Wm S Frock</u>		Address <u>same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 yrs.</u> DUE TO (c) <u>4 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1952</u> to <u>Feb 18, 1962</u> that I last saw the deceased alive on <u>Feb 15, 1962</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E Reese Wilkens</u> M.D.				ADDRESS (Street, city or town, state) <u>15 Kemper Ave</u> DATE SIGNED <u>2/19/62</u>			
PHYSICIAN'S NAME (Type) <u>E Reese Wilkens</u>				<u>Westminster, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Royal New Windsor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u>				24a. REC'D BY REGISTRAR <u>Feb 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01710

CERTIFICATE OF DEATH

01710

(M)

[Faint, illegible text, likely bleed-through from the reverse side of the document]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01737

01720

1. PLACE OF DEATH e. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 204 Glenn St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ella Elizabeth GORMAN				4. DATE OF DEATH Month Day Year February 4, 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Milton White				14. MOTHER'S MAIDEN NAME Harriett Brotemarkel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield State Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
Involuntional psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-9-40 , 19....., to 2-4-62 , 19....., that (I) (we) last saw the deceased alive on 2-4-62 , 19....., and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Naci N. Buyukunsal 22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Sykesville, Maryland		22b. DATE SIGNED 2-4-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 7- 1962		23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				25a. REC'D BY REGISTRAR 404 Decatur Street Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Krasner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Man & Boy

Man & Boy

01738

CERTIFICATE OF DEATH

01721

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b. 1 year 7mo 6da. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore city c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1230 E. Belvedere Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Leonard Hebble		4. DATE OF DEATH Month Day Year Feb. 6 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-84
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR 5 mos 8 days	11. IF UNDER 24 HRS. 16 hrs 20 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Hebble	
14. MOTHER'S MAIDEN NAME Christine Wittig		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 136-05-3136		17. INFORMANT Address Springfield State Hospital Record Sykesville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Inanition due to old age Conditions, if any, which gave rise to immediate cause (b) 4-2-2-1 (a), stating the underlying cause last. (c) A.S.C.V.D.			INTERVAL BETWEEN ONSET AND DEATH MD
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. Associated with cerebral Arteriosclerosis with Psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-11-60 , 19....., to 2-6-62 , 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE 2-6-62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, Md.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/10/62	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION (City, town or county) (State) BALTO., MD.
24. FUNERAL DIRECTOR'S SIGNATURE Walter Miller - 2334 Jefferson St		25a. REC'D BY REGISTRAR DATE FEB 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten signature or text at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01722

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester MD</u>		c. LENGTH OF STAY IN 1b <u>15 MO</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Manchester MD</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HEINDEL, ANN LUCY</u>		4. DATE OF DEATH <u>FEBRUARY 7 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yak Co. Po.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Heindel</u>		14. MOTHER'S MAIDEN NAME <u>Catharine E. Dubbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Murrell Heindel</u>		Address <u>Manchester, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 443X DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> 1961, to <u>2-7</u> 1962 that (I) (we) last saw the deceased alive on <u>Jan 23 1962</u> , and that death occurred at <u>FA-M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u>		22b. DATE SIGNED <u>2-7-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>		22d. ADDRESS <u>Wampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 10 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Protest Hill</u>		23d. LOCATION (City, town, county) (State) <u>Yak Po</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Seiple</u>		24b. ADDRESS <u>Green Rock, Po</u>	
25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u>	
DATE <u>FEB 13 '62</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01740 CERTIFICATE OF DEATH 01723

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN it 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 d. STREET ADDRESS 8208 Loch Raven Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Kauper Helgert		4. DATE OF DEATH Month Day Year February 5, 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16, 1889 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Germany
13. FATHER'S NAME George Kauper		14. MOTHER'S MAIDEN NAME Margaret Norndorfer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. DUE TO (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction.			
20a. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-20-1962 to 2-5-1962 , that (I) (we) last saw the deceased alive on 2-5-1962 , and that death occurred at 8:45 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 2-5-62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield state Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB 9 1962	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEM.	23d. LOCATION (City, town or county) (State) NORTH AVE & GAY ST MD
24. FUNERAL DIRECTOR'S SIGNATURE DIPPEL BROS ADDRESS 7110 BELAIR ROAD.		25a. REC'D BY REGISTRAR DATE FEB 7 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01741

01724

1. PLACE OF DEATH e. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXXX Frederick Street</u>				d. STREET ADDRESS <u>Frederick Street</u>					
3. NAME OF DECEASED (Type or print) <u>Pius Leo Hemler</u>				4. DATE OF DEATH <u>February 15, 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1981</u>			
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Hardware</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Louis J. Hemler</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Goulden</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>213-01-3804</u>					
17. INFORMANT <u>Mr. James D. Hemler, Taneytown, Maryland</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>151X</u> (b) <u>Perforation of Carcinoma of Stomach</u> DUE TO (c) <u>Carcinoma of Stomach</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>								INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u> <u>9 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>59</u> to <u>2/15</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>5/14</u> , 19 <u>62</u> , and that death occurred at <u>7:20 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>E. Ambler Thompson</u>				M.D. <u> </u>		22b. DATE SIGNED <u>2/16/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson</u>				22d. ADDRESS <u>Taneytown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		23d. LOCATION (City, town or county) <u>Taneytown, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Skiles</u> <u>C.O. Fuss & Son</u>				ADDRESS <u>Taneytown, Maryland</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 19 1962</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01742 CERTIFICATE OF DEATH 01725

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> c. LENGTH OF STAY IN 1b <i>MARYLAND</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll County General Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Manchester, Md.</i> d. STREET ADDRESS <i>104 Westminster St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Horatio C Hunt</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>21</i> Year <i>1962</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-4-87</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>21</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired hardware</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carroll Co. Md</i>	
11. BIRTHPLACE (County, State, or foreign country) <i>MSA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Hunt</i>		14. MOTHER'S MAIDEN NAME <i>Mary Greps</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Hypertensive arteriosclerosis</i> (a), stating the underlying cause last. (c) <i>Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <i>Sept 1947</i> to <i>Feb 21 1962</i> , That (1) (we) last saw the deceased alive on <i>Feb 20 1961</i> , and that death occurred at <i>3:45 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W H Foard</i>		22b. DATE SIGNED <i>2-21-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Foard, M.D.</i>		22d. ADDRESS <i>Manchester, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>2/24/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Manchester Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Carroll Co</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Bucker Fenner Jr</i>		25. REGISTRAR'S SIGNATURE <i>John J. Fenner</i>	
26. REC'D BY REGISTRAR <i>John J. Fenner</i>		27. DATE <i>FEB 23 1962</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01743

01726

1. PLACE OF DEATH a. COUNTY <u>Canoll Co.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> c. LENGTH OF STAY in b. <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nurs. Hm.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>_____</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> d. STREET ADDRESS <u>1507 1st Ave SE</u> <u>3401-4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JACOB HARRY IRWIN</u> First Middle Last 4. DATE OF DEATH <u>2-12-1962</u> Month Day Year			5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-1-1885</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Code Co</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>MD</u>			13. FATHER'S NAME <u>Wm.</u> 14. MOTHER'S MAIDEN NAME <u>Ely Lowe</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>_____</u> 16. SOCIAL SECURITY NO. <u>_____</u> 17. INFORMANT <u>_____</u> Address <u>_____</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerotic heart dis.</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>pneumonia, lesion of lower colon,</u> DUE TO (c) <u>herpes simplex</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>0960</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>		
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u> 20f. (City or town) (County) (State) <u>_____</u>			21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>Feb</u> , to <u>Feb</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>12 Feb</u> , 19 <u>62</u> , and that death occurred <u>4 P.M.</u> from the causes and on the date stated above.		
22a. SIGNATURE <u>Howard E. Hall</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>_____</u>			22b. DATE SIGNED <u>13 Feb 62</u> 22d. ADDRESS <u>Spencer, Md 137a 62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> 23b. DATE THEREOF <u>2-16-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u> 23d. LOCATION (City, town or county) (State) <u>Balto Md</u>			24. FUNERAL DIRECTOR'S SIGNATURE <u>McCall, Funeral Hm</u> ADDRESS <u>130 E Fort Ave</u> 25a. REC'D BY REGISTRAR <u>_____</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u> DATE <u>FEB 16 '62</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01744

CERTIFICATE OF DEATH

01727

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b. 4yrs. 10mos. 8days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville d. STREET ADDRESS North St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Rahy Keadle		4. DATE OF DEATH February 11, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1890 70 1/2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Maryland	
13. FATHER'S NAME Benjamin Shadrec		14. MOTHER'S MAIDEN NAME Emma Anthony	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 4 20.00 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Generalized arteriosclerosis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-3- 1957, to February 11, 1962 that (I) (we) last saw the deceased alive on February 11, 1962, and that death occurred at 5:08 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo, M.D.		22b. DATE SIGNED 2/12/62	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/14/62	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01745 CERTIFICATE OF DEATH 01728

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSP</u>		d. STREET ADDRESS <u>26 GIST. RD.</u>	
3. NAME OF DECEASED (Type or print) <u>DEVEN KAY LAW</u>		4. DATE OF DEATH <u>FEBRUARY 18 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 16, 1962</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>2</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alton D. Law</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hornor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Alton D. Law</u>	
17. INFORMANT <u>Alton D. Law</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>PREMATURE (24 WKS GESTATION)</u> (b) <u>WGT 11lbs 5oz AT BIRTH</u> (c) <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/16, 1962</u> to <u>2/18, 1962</u> , that (I) (we) last saw the deceased alive on <u>2/17, 1962</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William I. Stewart</u> M.D.		22b. DATE SIGNED <u>2/18/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>19 RIDGE RD. WESTMINSTER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/19/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Allentown, Pa. Montgomery County</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Moyer, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>Anthony S. Kline</u> 25b. REGISTRAR'S SIGNATURE <u>2/23/62</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01746

CERTIFICATE OF DEATH

01729

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washburne</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washburne</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Rd Hook Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County Civil Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie B. LOCKARD</u>		4. DATE OF DEATH <u>Feb. 3 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Olive Beamer</u>	
14. MOTHER'S MAIDEN NAME <u>Hester A. R. Hook</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Harriet J. Lockard</u> Address <u>Same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> 260X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> e.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Feb 3</u> , 1962, that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 1962, and that death occurred at <u>5:34 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James J. Marsh</u> M.D.		22b. DATE SIGNED <u>2-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES J. MARSH</u>		22d. ADDRESS <u>Washburne Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/6/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Smallwood Carroll Co. Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr.</u> ADDRESS <u>Washburne Md</u>		25a. RECEIVED BY REGISTRAR <u>Feb 6 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "James", "Harris", and "Harris" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01747

01730

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 18yrs.6mos.7da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle B. Last LOWRY		4. DATE OF DEATH Month February Day 27 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-84
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian J. Willinger		14. MOTHER'S MAIDEN NAME Rachel J. Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - old age - inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-20 1943 , to 2-27 1962 , that we last saw the deceased alive on 2-27 19 62 , and that death occurred at 9 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Naci N. Buyukunsal, M.D.		22b. DATE SIGNED 2-27-62	
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.		22d. ADDRESS Springfield State Hospital - Sykesville, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles Rouzer		25a. REC'D BY REGISTRAR DATE MAR 1 '62	
ADDRESS Hagerstown Md		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

01730

EXTRA-SOFT

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CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01748

01731

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b week	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) unknown		15x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Susan Middle Chorman Last Mack		4. DATE OF DEATH Month 2 Day 24 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with heart failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chronic brain syndrome caused by cerebral arterio		sclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/17 , 1962 , to 2/24 , 1962 , that (I) (we) last saw the deceased alive on 2/24 , 1962 , and that death occurred at 3:35 pm from the causes and on the date stated above.			
22a. SIGNATURE Adnan Sonmez M.D.		22b. DATE SIGNED 2/24/62	
22c. PHYSICIAN'S NAME (Type) Adnan M. Sonmez, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 3 1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Leban		23d. LOCATION (City, town, or county) (State) Etchison, Montgomery Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR MAR 6 62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01749

CERTIFICATE OF DEATH

01732

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>6 yrs./8 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore #18</u> d. STREET ADDRESS <u>3805 Elkader Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Norma</u> First Middle Last 4. DATE OF DEATH <u>February 24, 1962</u> Month Day Year				5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>2/9/73</u> 9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jessie McCaffery</u> 14. MOTHER'S MAIDEN NAME <u>Mary Ellen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Springfield State Hospital, Sykesville, Md.</u> Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>A.S.C.V.D. with compensated heart failure</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>C.B.S. assoc. with senility.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>6/28/55</u> to <u>2/24/62</u> , 19 <u>19</u> , that (I) (we) last saw the deceased alive on <u>2/24/62</u> , 19 <u>19</u> , and that death occurred at <u>6:25 a.m.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Adnan Sonmez M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Adnan Sonmez, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>2/24/62</u> 22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/27/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ruck Inc</u> ADDRESS <u>5305 HARFORD Rd.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 may be retained by the hospital or attending physician and the original certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01750

01733

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u> c. LENGTH OF STAY IN 1b <u>1y. 8m. 8d.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>808 St. Paul Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lora</u> Middle <u>-</u> Last <u>McMahon</u>		4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Franklin Weeks</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) <u>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</u> } DUE TO (e), stating the underlying cause last. (c) _____		17. INFORMANT Address <u>Springfield Hospital records - Sykesville, Md.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o.m. _____ p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/13/1960</u> to <u>2/21/1962</u> , that <u>he</u> (we) last saw the deceased alive on <u>2/21/1961</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Naci N. Buyakunsal, M.D.</u>		22b. DATE SIGNED <u>2/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Naci N. Buyakunsal, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/22/62 2nd Ancestry Board</u>	23b. DATE THEREOF <u>2/22/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Ind</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 1 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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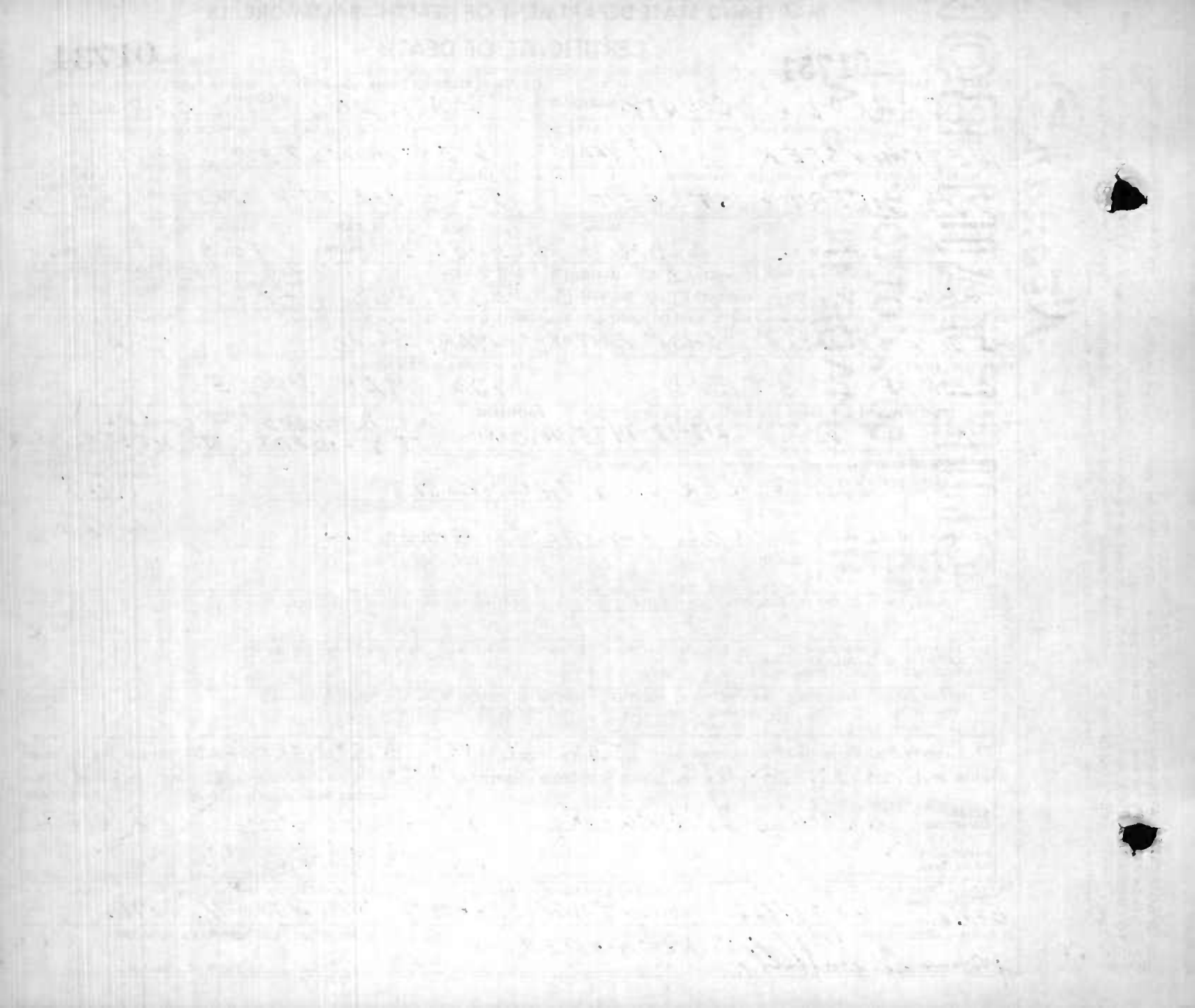
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

Reg. Dist. **01734**

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 19 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 1/2 LIBERTY STREET		e. STREET ADDRESS 155 1/2 LIBERTY STREET	
3. NAME OF DECEASED (Type or print) BESSIE STEM MICHAEL		4. DATE OF DEATH Month FEB Day 1 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 13, 1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE C. STEM		14. MOTHER'S MAIDEN NAME IDA MAE POOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-18-7435	
17. INFORMANT MR. BERNARD MICHAEL		Address 55 1/2 LIBERTY ST. WESTMINSTER.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 MIN 4 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY, 1958 , to FEBRUARY 1, 1962 that I last saw the deceased alive on JANUARY 12, 1962 , and that death occurred at 2:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William I. Stewart, M.D.		DATE SIGNED 2/1/62	
PHYSICIAN'S NAME (Type) WESTMINSTER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/3/1962	
22c. NAME OF CEMETERY OR CREMATORY UNIONTOWN CEMETERY		22d. LOCATION (City, town, or county) (State) UNIONTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell		24a. REC'D BY REGISTRAR FEB 2 '62	
ADDRESS WESTMINSTER, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01752 CERTIFICATE OF DEATH 01735

1. PLACE OF DEATH e. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Near Winfield</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Near Winfield</u>	
c. LENGTH OF STAY IN TB <u>2 Yrs.</u>		d. STREET ADDRESS <u>R. D. 5, Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R. D. 5, Westminster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>C. ERNEST MULLINIX</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John T. Mullinix</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Dillon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mr. E. Ray Mullinix,</u>		Address <u>Same as No. 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic C.V.D.</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/16/62</u> to <u>2/22/62</u> , that (I) (we) last saw the deceased alive on <u>2/22/62</u> , and that death occurred at <u>11:50 P.</u> from the causes and on the date stated above.			
22e. SIGNATURE <u>M. E. Robertson</u>		22b. DATE SIGNED <u>2/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Robertson, M. D.</u>		22d. ADDRESS <u>New Windsor, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 25, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Mt. Airy, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Box 241, Sykesville, Md.</u>		25e. REC'D BY REGISTRAR <u>DATE FEB 26 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Anthony S. Knaus</u>			

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Continental
Cable

M.E. Robertson

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2 1/2 lbs

New Wilson, Ark

L. E. Robertson, N. D.

Partial
Box 2, 1902
C. H. Wilson, Box 2, Sycamore, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01753					01736				
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 30yrs. 1mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont 10X-2 d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Edward Munshower					4. DATE OF DEATH Month Day Year February 4, 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1890		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Munshower					14. MOTHER'S MAIDEN NAME Emma Yinger				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) -			16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Manic depressive reaction, other. Cancer of rectum.								INTERVAL BETWEEN ONSET AND DEATH 2 - 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick (County) Maryland (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from January 4, 1962 to February 4, 1962 , that (I) (we) last saw the deceased alive on February 4, 1962 , and that death occurred at 8:20 PM from the causes and on the date stated above.									
22a. SIGNATURE Agustin del Campo M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/5/62		
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					22d. ADDRESS Springfield Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-7-62		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Maryland (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE MR. J. H. ... ADDRESS Frederick, Md.					25a. REC'D BY REGISTRAR 7 '62		25b. REGISTRAR'S SIGNATURE ...		

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Serial

2-1-82

John Oliver, Secretary

Secretary, Wyoming

01754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01737

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keyville		c. LENGTH OF STAY IN b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keyville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Ephriam Last Myers				4. DATE OF DEATH Month February Day 3 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1882	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 7 Days 9	IF UNDER 24 HRS. Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David P. Myers				14. MOTHER'S MAIDEN NAME Elizabeth Stambaugh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 219-12-0159		17. INFORMANT Address Mrs. Iva Parker, Box 404 Sherwood Rd. Owings Mill			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.	2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> CARROLL 2/4/62 Address (Street, city, town, or county) Keyville, Carroll, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1962		22c. NAME OF CEMETERY OR CREMATORY Keyville Cemetery		22d. LOCATION (City, town, or country) (State) Keyville, Carroll, Maryland	
23. FUNERAL DIRECTOR John H. Skiles C. J. Fuss & Son, Taneytown, Maryland				24a. REC'D BY REGISTRAR Feb 6 '62		24b. REGISTRAR'S SIGNATURE Charles L. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01755 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01738

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7yrs. 9mos. 9days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 1509-2			
f. STREET ADDRESS 408 Park Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Carey Gover Orrison				4. DATE OF DEATH Month Day Year February 13, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 18, 1869	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Gover				14. MOTHER'S MAIDEN NAME Mary Stone			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, with senile brain disease with psychotic reaction. Fracture, both inferior rami. Bilateral pneumonia.							INTERVAL BETWEEN ONSET AND DEATH Hours Years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1/18/62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
DATE SIGNED 2/13/62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/62		22c. NAME OF CEMETERY OR CREMATORY Lovettsville Union Cemetery		22d. LOCATION (City, town, or country) (State) Lovettsville, Va.	
23. FUNERAL DIRECTOR Tyson Wheeler 2131 E. Adams Rockville, Md.				24a. REC'D BY REGISTRAR DATE FEB 19 '62		24b. REGISTRAR'S SIGNATURE Arthur L. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01756

CERTIFICATE OF DEATH

01739

Item 2 Film G307 2/19/62 iwk

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 4ly. 7m. 10d. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS unknown-- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Helen Middle M. Last Robey			4. DATE OF DEATH Month 2 Day 13 Year 19 62		
5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/8/1887 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 10b. KIND OF BUSINESS OR INDUSTRY REGISTERED NURSE 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME E. Porter Robey 14. MOTHER'S MAIDEN NAME MARY A. Linthicum			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Address Springfield Hospital records, Sykesville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Schizophrenic Reaction, Hebephrenic Type.			INTERVAL BETWEEN ONSET AND DEATH 3 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that XX (this hospital) attended the deceased from 7/3/1962 to 2/13/1962 , that (X) (we) last saw the deceased alive on 2/13/1962 , and that death occurred at 3:10 PM from the causes and on the date stated above.		
22a. SIGNATURE Naci N. Buyukunsal 22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.			22b. DATE SIGNED 2/13/62 22d. ADDRESS Springfield State Hospital Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 2/15/62 23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL 23d. LOCATION (City, town or county) (State) BALTIMORE, MD.			25a. REC'D BY REGISTRAR FEB 15 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna		
24. FUNERAL DIRECTOR'S SIGNATURE H W Meares + son 805 N. Calvert St. J. Couley ADDRESS					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01757

CERTIFICATE OF DEATH

01740

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Viola</u> Last <u>Salley</u>		4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5, 1900</u>
9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Harry Hare</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-8339</u> 17. INFORMANT <u>Mr. James Salley, Route #1, Taneytown, Maryland</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Stroke 2 1/2 Months ago</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>8 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>July 7</u> , 19 <u>51</u> , to <u>2-12</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 19 <u>62</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Reginald T. Gobel</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>245 Baltimore Street, Hanover, Pa.</u>	22b. DATE SIGNED <u>2-13-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 15, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	23d. LOCATION (City, town or county) <u>Taneytown, Maryland</u> (State) <u> </u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>John H. Skiles</u> <u>C.O. Fuss & Son</u>		25a. REC'D BY REGISTRAR <u>FEB 15 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 12 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MYERSVILLE		d. STREET ADDRESS 10 X - 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		3. NAME OF DECEASED (Type or print) MIRIAM PAULINE SHEPLEY		First Middle Last		4. DATE OF DEATH Month Day Year 2 4 19 62		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1904		9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Frederick, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Lizer		14. MOTHER'S MAIDEN NAME Estie Shepley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-40-0392		17. INFORMANT Clarence F. Shepley, Myersville, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wounds of neck DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot self in neck		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. 8:00 Month, Day, Year 1-12 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Myersville, Frederick Co., Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Peter W. Rieckert, M.D.		M.D. Peter W. Rieckert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-5-62		22b. DATE THEREOF Feb. 7, 1962		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran		22d. LOCATION (City, town, or country) (State) Myersville, Fred. Co. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23. FUNERAL DIRECTOR Paul F. Bittle, Myersville, Md.		ADDRESS Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR FEB 8 '62		24b. REGISTRAR'S SIGNATURE Wm. L. Thorne		DATE											



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SAVING

December 31, 1907

Frederick Co., Md.

own home

home

Little Mary

Little Mary

220-40-0000 Clarence F. Appleby, Maryland, Md.

No.

one of several

one of several

Frederick

home

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Small 700.7.1902 St. Paul's Lutheran Hospital, Fred. Co.

Paul F. Little, Maryland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

01759

Reg. No. 01742

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>179 Willis St.</u>		d. STREET ADDRESS <u>179 Willis St.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS DONALD SHRIVER</u>		4. DATE OF DEATH <u>FEB. 7 1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired mechanical engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa</u>	
13. FATHER'S NAME <u>Edward Haines Shriver</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>182-09-9386</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1958</u> to <u>Feb 7 1962</u> , that I last saw the deceased alive on <u>Feb 7 1962</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster Md</u>	
DATE SIGNED <u>2-7-62</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Myers, Jr., Westminster, Md</u>		24a. REC'D BY REGISTRAR <u>Feb 13 '62</u>	
ADDRESS <u>Westminster, Md</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Prange</u>	

11780

CERTIFICATE OF DEATH

01218



01710

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Alphington

William W. Lark House

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01761

01744

1. PLACE OF DEATH a. COUNTY <u>Cornell</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cornell County General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Cornell</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>Rt 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CALVIN E SLONAKER</u> First Middle Last		4. DATE OF DEATH <u>Feb 9 1962</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-13-67</u> 9. AGE (In years last birthday) <u>94</u> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bliss Smith (Retired)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>John Slonaker</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		17. INFORMANT <u>Mrs. Cora Lawyer, Rt 1, Westminster, Maryland</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Arterio Sclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2 - Feb 9, 1962</u> to <u>Feb 9, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 9, 1962</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James T. Marsh</u> M.D.		22b. DATE SIGNED <u>2-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>		22d. ADDRESS <u>Westminster</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Run, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss & Son</u> ADDRESS <u>Taneytown, Maryland</u>		25. REC'D BY REGISTRAR <u>FEB 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

VR A15 (4)
15M 9/60

14510

(M)

(1)

University, Maryland

College Park, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01762
01745

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 3yrs.7mos.23days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto. City City ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 d. STREET ADDRESS 1740 Harford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Frank Middle Snyder Last Snyder				4. DATE OF DEATH Month February Day 12 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 30, 1877			
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4		IF UNDER 24 HRS. Hours 12 Min. 00					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Frank Snyder				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) -				16. SOCIAL SECURITY NO. 212-05-3467		17. INFORMANT Springfield Hospital Records Address -			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4-3-4-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Congestive heart failure (a), stating the underlying cause last. DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH Days 1 week			
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with dist. of metabolism, with senile brain disease with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. - p.m. -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 19, 1958 to February 12, 1962 that (I) (we) last saw the deceased alive on February 11, 1962 , and that death occurred at 2:10 AM from the causes and on the date stated above.									
22a. SIGNATURE Agustin del Campo M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 2/12/62			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/15/62		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE Cem.		23d. LOCATION (City, town or county) (State) BALTIMORE Md			
24. FUNERAL DIRECTOR'S SIGNATURE L. F. Ruck ADDRESS 5305 HARFORD RD.				25a. REC'D BY REGISTRAR CLARENCE L. HARRIS DATE FEB 13 '62		25b. REGISTRAR'S SIGNATURE CLARENCE L. HARRIS			

11710

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(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01763

01746

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marcheston</u>		c. LENGTH OF STAY IN 1b <u>19 MO</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hampstead Rural</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>	
d. STREET ADDRESS <u>Hockessville ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LINNIE</u> Middle <u>ESTHER</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min. <u>00</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>219-36-1364</u>	
17. INFORMANT <u>Mr. Wilson Bill</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Parkinson Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1 1950</u> to <u>Feb 4 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 2 1962</u> and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.		ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>Hampstead, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-7-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		23d. LOCATION (City, town, or county) (State) <u>Small Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Elmer</u>		ADDRESS <u>Hampstead Md</u>	
25a. REC'D BY REGISTRAR <u>Feb 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinnard</u>	

CERTIFICATE OF DEATH

11763

11763

James William
born 1870
died 1910
cause of death
heart disease
buried in
Catholic
Church
at
St. Louis
Mo.
1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01764

CERTIFICATE OF DEATH

Reg. Dist. No. 01747

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>CHURCH ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHARINE SLINGLUFF STAUFFER</u>				4. DATE OF DEATH Month Day Year <u>FEB 22 1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 22-1867</u>	
9. AGE (In years last birthday) yrs. <u>94</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS SLINGLUFF</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET CROMWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ROBERT SLINGLUFF NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>Feb 22, 1962</u> , that I last saw the deceased alive on <u>Feb 15, 1962</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Tharal</u> M.D.				ADDRESS (Street, city or town, state) <u>Windsor, Md</u> DATE SIGNED <u>2/23/62</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/25/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D N Hartley & Sons, New Windsor, Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 27 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO DIRECTOR: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Items 7-11-12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01748											
Item 4 Film G309 3/20/62 iwk Film G310 4/4/62											
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 WESTMINISTER d. STREET ADDRESS 1 Mayberry Road					
14. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTMINISTER						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last DAVID TINKOSIC						4. DATE OF DEATH Month Day Year Feb. 25 (Presumed) 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) unknown Yugoslavia		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest - during a period of despondency							
20c. TIME OF INJURY Hour a.m. p.m. ? 2 25 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Westminister Carroll		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE PETER W. RIECKERT, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 2-26-62		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) Baltimore Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-27-62		22c. NAME OF CEMETERY OR CREMATORY V. Med. Schol				22d. LOCATION (City, town, or country) (State) Baltimore Md.			
23. FUNERAL DIRECTOR						24a. REC'D BY REGISTRAR DATE MAR 2 '62		24b. REGISTRAR'S SIGNATURE L. K. K...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01766

01749

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Houdersville Ave</u>		d. STREET ADDRESS <u>12 Houdersville ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>CRONNEN</u> Middle <u>Tipton</u> Last		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1962</u>	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11 - 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. B. Tipton</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bentz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-34-4753</u>	
17. INFORMANT <u>Mrs. Addie Tipton</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 4, 1962</u> to <u>Feb 7, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 6, 1962</u> and that death occurred at <u>8:13 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
22b. DATE <u>Feb 7, 1962</u>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-10-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Elmer</u>		ADDRESS <u>Hampstead Md</u>	
25a. REC'D BY REGISTRAR <u>DATE 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

(M)

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be a form for a death certificate, with fields for name, date, and other details.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01767		01750	
1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i> c. LENGTH OF STAY IN Md <i>Life</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN E. TROTT</i>		4. DATE OF DEATH <i>Feb. 22 1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1871</i>
9. AGE (In years last birthday) <i>90</i>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during normal working days, even if retired) <i>Carpenter Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel Trott</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs Clyde Wilson - Sylkesville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO (b) <i>Pr. heart failure</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <i>Generalized atherosclerosis</i> DUE TO (c) <i>Urinary fistula</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-7-60</i> to <i>2-22-62</i> , that (I) (we) last saw the deceased alive on <i>2-18-62</i> , and that death occurred <i>2-20-62</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Sani Okutman</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>		22d. ADDRESS <i>Sylkesville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>2/24/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Oakland</i>	23d. LOCATION (City, town or county) (State) <i>Maryland Md - Sylkesville Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth H. Haight</i>		25a. REC'D BY REGISTRAR <i>Feb 27 '62</i>	
ADDRESS <i>Sylkesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01768

CERTIFICATE OF DEATH

01751

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield, Sykesville 7 mos. 9dys c. LENGTH OF STAY IN 1b 7 mos. 9dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart Mines d. STREET ADDRESS Box 135 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Harris Twigg		4. DATE OF DEATH Month February Day 22 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 22 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Harris	
14. MOTHER'S MAIDEN NAME Catherine Cross		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (b) Old age inanition. (c) Old age inanition. DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. with senile brain disease with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH Years Years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) 7-13-1962, 10:15 a.m. 2-22-1962
21. I certify that (I) (this hospital) attended the deceased from 7-13-1962 , 10:15 a.m. , 2-22-1962 , that (I) (we) last saw the deceased alive on 2-22-1962 , and that death occurred at 10:15 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Naci Buyukunsal, M.D.		22b. DATE SIGNED 2-22-62	
22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-25-62	23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	23d. LOCATION (City, town or county) (State) Frostburg, Md.
24 FUNERAL DIRECTOR'S SIGNATURE Joseph R. Rust		25a. REC'D BY REGISTRAR DATE FEB 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

01510

DEPARTMENT OF DEATH

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01769

CERTIFICATE OF DEATH

01752

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3 VAL-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>				d. STREET ADDRESS <u>8606 Bolton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE BROWN Walsh</u>				4. DATE OF DEATH Month Day Year <u>February 12, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1876</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John F. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>JANE WRIGHT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>O. HENRY Walsh</u> Address <u>5848 Selman Ave</u> <u>TRIBUTUS MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Glomerular Nephritis</u> DUE TO <u>Arterio-Sclerotic Cardio-Penal Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>—</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1959</u> to <u>February 12, 1962</u> that (I) (we) last saw the deceased alive on <u>February 12, 1962</u> and that death occurred at <u>11:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-12-62</u>	
22. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>HAMPSTEAD Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 16, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road, Balt., 12 Md.</u>				25a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01770

01753

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 11days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
3. NAME OF DECEASED (Type or print) Howard Jefferson Walters		d. STREET ADDRESS 2701 Matthews St.	
5. SEX Male		4. DATE OF DEATH February 12, 1962	
6. COLOR OR RACE White		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Ambrose Walters		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Catherine Dietrick	
16. SOCIAL SECURITY NO. 216-07-9876		17. INFORMANT Springfield Hospital Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary abscesses DUE TO (c) Bed sores		INTERVAL BETWEEN ONSET AND DEATH Days Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 31, 1961 to February 12, 1962 , that (I) (we) last saw the deceased alive on February 12, 1962 , and that death occurred at 1:30PM from the causes and on the date stated above.		22a. SIGNATURE Agustin del Campo M.D.	
22b. DATE SIGNED 2/12/62		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield State Hospital, Sykesville, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-16-62	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2		25a. REC'D BY REGISTRAR DATE FEB 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

01728

CLASSIFICATION OF DATA

01728

M



CERTIFICATE OF DEATH

01771

01754

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN TB 2mos. 19dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 d. STREET ADDRESS 7708 Old Battle Grove Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn Pyfle Williams				4. DATE OF DEATH Month Day Year February 26 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1893	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Pete Pyfle				14. MOTHER'S MAIDEN NAME -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Infected bed sores DUE TO (c) - Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH Days weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
C.B.S. associated with cerebral arteriosclerosis, without psychosis.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-7-1961 , to 2-26-1962 , that (I) (we) last saw the deceased alive on 2-26-1962 , and that death occurred at 7:20 p.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22b. DATE SIGNED 2-26-62		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 3, 1962		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town or county) (State) Fairmont, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DHDA				25a. REC'D BY REGISTRAR 1 '62		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01772

01755

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>59 days.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u> d. STREET ADDRESS <u>3020 Texas Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First Middle Last 4. DATE OF DEATH <u>2</u> <u>10</u> <u>19 62</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>November 23, 1883</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR <u>2</u> Months <u>10</u> Days IF UNDER 24 HRS. <u>19</u> Hours <u>62</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.- Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry A. Wise</u> 14. MOTHER'S MAIDEN NAME <u>Minerva E. Pifer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Springfield Hospital Records</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4200 } DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO <u>Generalized arteriosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left hip</u> <u>C.B.S. assoc. with senile brain disease, without psychotic reaction.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to the floor while trying to sit down on a foot stool</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>12-27, 1961</u> Hour e.m. <u>3.05</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u> 20f. (City or town) <u>Sykesville</u> (County) <u>Carroll</u> (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>12-13-1961</u> to <u>2-10-1962</u> , that (I) (we) last saw the deceased alive on <u>2-10-1962</u> , and that death occurred at <u>9P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Agustin del Campo</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-14-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u> 23d. LOCATION (City, town or county) <u>Stephens City, Va.</u> (State) <u>Va.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight</u> ADDRESS <u>Sykesville, Md.</u> 25a. REC'D BY REGISTRAR <u>FEB 15 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Clifford E. Hume</u>	

01755

RECEIVED OF DEATH

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